AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION JAIL HEALTH SERVICES

Public Health is not obligated to honor this request unless all portlons are completed.

	(give complete name & address)	
	· ·	
	s of:	
	Client Name	Alias (Optional)
Records will be relea	Client Phone #	Date of Birth
Person & Institution Aff	filiation	14.4
Street Address	30	City/State/Zip
Phone Number		Number (Optional)
Date(s) of somions rec	wastod:	
Date(s) of services req	(If no date given: the la	st incarceration information will be released)
For the purpose of: □	· =	conal 🗆 other (describe)
Please verify what you Release Medical Her Other Public Health I Verbal Information E	alth Records	
trademies du com		
(AIDS Virus), positive sexu	ds may contain information regardir ually transmitted diseases, drug and	ng the testing, diagnosis, and/or treatment of HIV /or alcohol abuse, mental illness or psychiatric treatmen
(AIDS Virus), positive sext When checked, this au Drug or alcohol abus	ually transmitted diseases, drug and athorization Excludes release of	or alcohol abuse, mental illness or psychiatric treatmen
When checked, this au ☐ Drug or alcohol abus ☐ Confirmed STD test This authorization exp	ually transmitted diseases, drug and uthorization <u>Excludes</u> release of the diagnosis or treatment results and/or treatment lires (insert date or event, <u>inval</u>	or alcohol abuse, mental illness or psychiatric treatmen of the following information: HIV (AIDS) testing/treatment Psychiatric iid if left blank)
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Department of Veterans Affairs

REQUEST FOR AND CONSENT TO RELEASE OF MEDICAL RECORDS PROTECTED BY 38 U.S.C. 7332

PAPERWORK REDUCTION ACT INFORMATION: Public reporting burden for this collection of information is estimated to average 2 minutes per response, including the time for reviewing instruction, searching existing data sources, gathering and maintaining the data needed and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden to VA Clearance Officer (723), 810 Vermont Avenue NW, Washington DC 20420, and to the Office of Information and Regulatory Affairs, Paperwork Reduction Project (2900-0260), Office of Management and Budget, Washington DC 20503. DO NOT send applications to this address.

(2900-0260), Office of Management and Budget, Washington DC 20503. D	O NOT send applications to the	is address.
The execution of this form does not authorize the release of information solicited under Title 38, U.S.C. and will authorize release of information However, if the information is not furnished, Department of Veterans Affairs	you specify. Your disclosu will be unable to comply with	re of the information requested on this form is voluntary, the request.
ENTER BELOW THE PATIENT'S NAME AND SOCIAL SECU	RITY NUMBER IF THE I	PATIENT DATA CARD IMPRINT IS NOT USED.
TO: Department of Veterans Affairs (Print or type name and address of Health care facility) VA Puget Sound Health Care System	PATIENT N	IAME (Last, First, Middle Initial)\
1660 S. Columbian Way	SOCIAL SE	CURITY NUMBER
Seattle, WA 98108-1597		
NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL OR TITLE		
VETERAN'S REQUEST: I request and authorize Department o organization, or individual named on this request. I understand that the condition(s):	ne information to be releas	ed included information regarding the following
DRUG ABUSE ALCOHOLISM OR ALCOHOL ABUSE	TESTING FOR OR INFI HUMAN IMMUNODI (HIV)	EFICIENCY VIRUS SICKLE CELL ANEMIA
INFORMATION REQUESTED: (Check applicable box(es) and or approximate dates covered by each)	d state the extent or nature	of the information to be disclosed, giving the dates
Copy of Hospital Summary Copy of Ou	utpatient Treatment Not	e(s) Other
Two way verbal and written information regarding a substance use disorder treatment records and housing	ll aspects of health og status.	care, including mental health and/or
Purpose(s) or need for which the information is to b ☐ Assist client in meeting legal requirements ☐ Assist with housing application ☐ Other:		Transfer Tx to another agency
AUTHORIZATION: I certify that this request has been m given above is accurate to the best of my knowledge. I under extent that action has already been taken to comply with it. authorized information may not be accomplished without my will automatically expire: (1) upon satisfaction of the need for under the following condition(s):	erstand that I may revo Redisclosure of my further written consent	ke this authorization at any time except to the medical records by those receiving the above. Without my express revocation, the consent
		horized to Sign for Patient
	'A USE ONLY	
IMPRINT Patient Data Card (Name, Address, Social Security Number)	Type and Extent of M	aterial Released
	Date Released	Released By:
		H

Sound Mental Health AUTHORIZATION to REQUEST, SHARE OR RELEASE HEALTHCARE INFORMATION Client Name: (F,M,L) Date of Birth: AKA: Date of Birth: SSN: Address: City/State/Zip Code: Information to be shared or released by: Name: Organization: KIMA/A MALL Organization: KIM						
Client Name: (F,M,L) Date of Birth: Address: City/State/Zip Code: Information to be shared or released by: Name: Name:						
Date of Birth: Address: City/State/Zip Code: Information to be shared or released by: Name: Name: Name:						
Address: City/State/Zip Code: Information to be shared or released by: Name: Name: Name:						
City/State/Zip Code: Information to be shared or released by: Name: Name: Name:						
Information to be shared or released by: Name: Name: Name:						
Name: Name:						
Organization: KIMIN 1944 Oppinm 10 1944 00 1						
Organization: KIMCOVITU REGIONAL VETERANS (JUST) Organization:						
SMH – Indicate contact/address information in next section. Address: Address:						
Address: Address: City/State/Zip: City/State/Zip:						
Phone: Phone:						
505 29 th Street SE 4240 Auburn Way North Auburn, WA 98002 4238 Auburn Way North Auburn, WA 98002 500 Auburn, WA						
253-876-7650 253-876-8900 253-876-7600 425-653-4900 206-444-7800						
Fax: 253-876-7851 Fax: 253-876-8980 Fax: 253-876-8980 Fax: 425-653-4939 Fax: 206-444-7890						
14270 NE 21 st Street 16225 NE 87 th St., Suite A-6 11629 Avondale Road 8705 166 th Ave NE						
Bellevue, WA 98007 Redmond, WA 98052 Redmond, WA 98052 Redmond, WA 98052 425-653-5000 425-869-4960 425-653-5070 425-869-6634						
Fax: 206-726-5790 Fax: 206-726-5790 Fax: 206-726-5790						
1600 East Olive Street 122 16 th Ave E 9706 4 th Ave NE, Suite 303 2719 East Madison, Suite 200						
Seattle, WA 98122 Seattle, WA 98112 Seattle, WA 98115 Seattle, WA 98112						
206-302-2200						
☐ This is a 90 day authorization to request or disclose healthcare information. OR						
☐ This authorization allows mutual exchange of information between the entities listed above in order to provide						
and/or coordinate care until 30 days after discharge from this episode of care, unless revoked by the client						
The person or organization listed above is:						
☐ Emergency/ Family Contact ☐ Care Provider ☐ Case Worker ☐ Care Coordinator ☐ CSO ☐ School-Based Care Contact						
The purpose of the request / disclosure is:						
☐ Care Coordination ☐ Referral ☐ Disability Confirmation ☐ Legal ☐ Other (specify)						
Specific Information to be disclosed:						
☐ Status Report ☐ Recent Treatment/Progress Notes ☐ Other: ☐ Information to Coordinate Care ☐ Discharge Summary						
☐ Initial Assessment ☐ Medication Information						
Psychlatric Evaluation Physical Health Information						
☐ Psychological Evaluation ☐ School Records/ IEP ☐ Treatment Plan ☐ CD Assessment						
If information is requested for specific dates, please note dates:						
I understand that my healthcare information/record contains information about my treatment and services I receive through a variety of programs						
offered at SMH. This may include Information about my mental health, alcohol and drug dependence, STDs and HIV / AIDS status and other specific areas (i.e., domestic violence) as it applies to my treatment and recovery program. I also understand that my records and healthcare information are						
protected under both Federal and State laws and cannot be disclosed or re-disclosed without my consent unless otherwise provided by law.						
I understand that one of the federal privacy laws, the Health Insurance Portability and Accountability Act (HIPAA), has limited applicability and protects						
the disclosure of information by and between nealincare providers, health information clearinghouses and health plans/health incurate. Little A. door						
not protect the disclosure and possible re-disclosure of personal health information to Individuals or organizations not covered by HIPAA. However, other federal and state laws do apply and will continue to protect my personal health information.						
This authorization to release or disclose information expires in 90 days unless it is an agreement to share information during this episode of care. My						
treatment at SWM is not conditioned on signing (his allinorization. This agreement to request, release or share information may be revoked by me in						
writing, at any time. The revocation will not have any effect on actions taken before the revocation is received by SMH. There may be charges associated with the release of healthcare information. These charges will not exceed the amounts allowable under State law.						
Client Client Client						
Client Signature: Date: / /						
Parent/Guardian Signature: Date: / /						
Relationship to Client: Parent Guardian-Appointed Guardian-Healthcare Power of Attorney						
Guardian-Other Specify:						

		Sound Mental	Health		MRN:		
AUTHORIZAT	ION to REQUEST	, SHARE O	R RELI	EASE HEALTH	CARE	NFOR	MATION
Client Name: (F,M,L)				AKA:			
Date of Birth:				SSN:			
City/State/Zip Code			T	Phone Number(s):			
Information to be sha	red or released by:		Informat	ion to be shared or rel	eased to:		
Name:			Name:				34
Organization:	ntact/address information	c Detense	Organiza				
Address:	Trace address information	in next section.	Address	 Indicate contact/add 	ress infor	nation in	next section.
City/State/Zip:			City/Stat				
Phone:			Phone:	П			
505 29 th Street SE Auburn, WA 98002 253-876-7650 Fax: 253-876-7651	4240 Auburn Way North Auburn, WA 98002 253-876-8900 Fax: 253-876-8980	4238 Auburn Wa Auburn, WA 986 253-876-760 Fax: 253-876-898	002 00	14216 NE 21 st Street Bellevue, WA 98007 425-653-4900 Fax: 425-653-4939	Tukwila 206	uthcenter , WA 9818 i-444-7800 5-444-7890	Blvd., Suite 200 8
14270 NE 21st Street Bellevue, WA 98007 425-653-5000 Fax: 206-726-5790	16225 NE 87 th St.,Sulte A-6 Redmond, WA 98052 425-869-4960 Fax: 206-726-5790	11629 Avondale Redmond, WA 9 425-653-507 Fax: 206-726-579	98052 '0	8705 166 th Ave NE Redmond, WA 98052 425-869-6634 Fax: 206-726-5790			
1600 East Olive Street Seattle, WA 98122 206-302-2200 Fax: 206-302-2210	122 16 th Ave E Seattle, WA 98112 206-302-2700	9706 4 th Ave NE, Seattle, WA 981 206-302-290 Fax: 206-302-27	15 0	2719 East Madison, Su Seattle, WA 98112 206-302-2600 Fax: 206-726-5769	ite 200		
and/or coordinate The person or or □ Emergency/ Fa □ Care Coordinate The purpose of the r □ Care Coordination Specific Information □ Status Report	request / disclosure is: Referral Disable to be disclosed: Recent Tr	r discharge fror is: Provider ☐ C ☐ S	n this epa ase Work chool-Bas	isode of care, unless er ed Care Contact	revoked	order to) provide lient.
☐ Information to Cool ☐ Initial Assessment ☐ Psychiatric Evaluat ☐ Psychological Evaluat ☐ Treatment Plan If information is requ	☐ Medication ☐ Physical H		tes:				
areas (I.e., domestic viole protected under both Federal understand that one of the disclosure of information of protect the disclosure other federal and state law. This authorization to releat treatment at SMH is not co	thcare information/record contar include information about my nce) as it applies to my treatme eral and State laws and cannot ne federal privacy laws, the Hea on by and between healthcare and possible re-disclosure of provision of apply and will continue to se or disclose information expire anditioned on signing this author	mental health, alcohont and recovery probe disclosed or re-calth Insurance Porta providers, health infersonal health information protect my personal res in 90 days unlessorization. This agrees in some protect my personal results agree in 90 days unlessorization. This agrees in general triangle in the source of the source o	ord and drug gram. I als disclosed w billity and A formation of nation to in il health info s it is an ag	dependence, STDs and he of understand that my reconstitution my consent unless of coountability Act (HIPAA), earinghouses and health produced or organizations formation.	IIV / AIDS s rds and hea therwise pre has limited lans/health not covered	status and of althcare info ovided by I applicability insurers. I by HIPAA	other specific formation are aw. y and protects HIPAA does . However,
associated with the releas	evocation will not have any effe e of healthcare information. Th	ect on actions taken	before the	revocation is received by S e amounts allowable unde	SMH. There r State law.	may be cl	narges
Client Signature: If Appropriate-					Date:	/	
Parent/Guardian Si					Date:		
Relationship to Client:	Parent Guardian-A Guardian-Other Specify:	ppointed L G	uardian-He 	althcare Power of Attorn	ey 		
						-	

		Sound Mental			MRN:	
AUTHORIZAT	TON to REQUEST	, SHARE OF	R RELE	EASE HEALTHO	CARE INFORMATION	
Client Name: (F,M,L		·		AKA:		
Date of Birth:				SSN:		
Address:						
City/State/Zip Code:				Phone Number(s):		
Information to be sha	red or released by:		Informati	ion to be shared or rel e	eased to:	
Name:	mara M. I. I cantaines		Name:			
	eparament of veteran		Organiza			
	ontact/address information i	in next section.			ress information in next section.	
Address:			Address:			
City/State/Zip:			City/Stat	e/Zip:		
Phone:			Phone:			
505 29 th Street SE Auburn, WA 98002 253-876-7650 Fax: 253-876-7651	ırn, WA 98002 Auburn, WA 98002 Auburn, WA 98 53-876-7650 253-876-8900 253-876-76		002 00	14216 NE 21 st Street Bellevue, WA 98007 425-653-4900 Fax: 425-653-4939	LJ 6100 Southcenter Blvd., Suite 200 Tukwila, WA 98188 206-444-7800 Fax: 206-444-7890	
14270 NE 21 st Street Bellevue, WA 98007 425-653-5000 Fax: 206-726-5790	16225 NE 87 th St.,Sulte A-6 Redmond, WA 98052 425-869-4960 Fax: 206-726-5790	11629 Avondale Redmond, WA 9 425-653-507 Fax: 206-726-579	98052 70	8705 166 th Ave NE Redmond, WA 98052 425-869-6634 Fax: 206-726-5790		
1600 East Olive Street Seattle, WA 98122 206-302-2200 Fax: 206-302-2210	Seattle, WA 98122 Seattle, WA 98112 Seattle, WA 98 206-302-2200 206-302-2700 206-302-29			Seattle, WA 98112 206-302-2600		
This is a 90 day	authorization to reque	st or disclose	healthcar	re information,		
and/or coordinat <u>The person or or</u> ☐ Emergency/ Fa	e care until 30 days after ganization listed above i mily Contact ☐ Care F	<i>r discharge fron <u>is:</u></i> Provider □ Ca	<i>n this epi</i> ase Worke	sode of care, unless er	above in order to provide revoked by the client.	
☐ Care Coordinat	tor CSO	S	chool-Bas	ed Care Contact		
☐ Care Coordination Specific Information ☐ Status Report ☐ Information to Coordination	rdinate Care	cility Confirmation reatment/Progress Summary		al ☐ Other (specify)	
Initial Assessment	Medication	n Information				

I understand that my healthcare information/record contains information about my treatment and services I receive through a variety of programs offered at SMH. This may include information about my mental health, alcohol and drug dependence, STDs and HIV / AIDS status and other specific areas (i.e., domestic violence) as it applies to my treatment and recovery program. I also understand that my records and healthcare information are protected under both Federal and State laws and cannot be disclosed or re-disclosed without my consent unless otherwise provided by law.

Physical Health Information

School Records/ IEP ☐ CD Assessment

If information is requested for specific dates, please note dates:

Psychiatric Evaluation

Psychological Evaluation

Psychological Education Treatment Plan

I understand that one of the federal privacy laws, the Health Insurance Portability and Accountability Act (HIPAA), has limited applicability and protects the disclosure of information by and between healthcare providers, health information clearinghouses and health plans/health insurers. HIPAA does not protect the disclosure and possible re-disclosure of personal health information to individuals or organizations not covered by HIPAA. However, other federal and state laws do apply and will continue to protect my personal health information.

This authorization to release or disclose information expires in 90 days unless it is an agreement to share information during this episode of care. My treatment at SMH is not conditioned on signing this authorization. This agreement to request, release or share information may be revoked by me, in writing, at any time. The revocation will not have any effect on actions taken before the revocation is received by SMH. There may be charges associated with the release of healthcare information. These charges will not exceed the amounts allowable under State law,

Client Signature:	Date:	/	/
If Appropriate-			
Parent/Guardian Signature:	Date:	/	/
Relationship to Client: Parent Guardian-Appointed Guardian-Other Specify:	☐ Guardian-Healthcare Power of Attorney		

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A	1014 DEGLISOT	Sound Mental				MRN:		
	ION to REQUEST	, SHARE O				CARE I	NFOR	MATION
Client Name: (F,M,L Date of Birth:)			AKA SSN				
Address:				JJIN				
City/State/Zip Code			F	Phor	ne Number(s):			
Information to be sha	red or released by:		Informati	ion t	o be shared or rel e	eased to:		
Name:			Name:		o so brianda or ren	Jasea to.		
Organization:			Organiza					
	ntact/address information	in next section.			dicate contact/addi	ress inforn	nation in	next section.
201 (201) 724			Address:					
Phone:			City/State Phone:	CIZIL	ν.			
			1 110110.					
505 29 th Street SE Auburn, WA 98002 253-876-7650 Fax: 253-876-7651	98002 Auburn, WA 98002 Auburn, WA 98 650 253-876-8900 253-876-760		002	Bellevue, WA 98007 Tukwila, WA 9818 425-653-4900 206-444-7800 Fax: 425-653-4939 Fax: 206-444-7890		WA 9818 444- 7800	Bivd., Suite 200 8	
14270 NE 21 st Street Bellevue, WA 98007 425-653-5000 Fax: 206-726-5790	16225 NE 87 th St.,Suite A-6 Redmond, WA 98052 425-869-4960 Fax: 206-726-5790	edmond, WA 98052 Redmond, WA 980 425-653-5070 425-653-5070			8705 166 th Ave NE Redmond, WA 98052 425-869-6634 Fax: 206-726-5790			
1600 East Olive Street Seattle, WA 98122 206-302-2200 Fax: 206-302-2210	122 16 th Ave E Seattle, WA 98112 206-302-2700	9706 4 th Ave NE, Seattle, WA 981 206-302-290 Fax: 206-302-27	15 0	ulte 303 2719 East Madison, Suite 200				
and/or coordinat		<i>r discharge fror <u>is:</u></i> Provider	n this epi ase Worke	isod er	the entities listed le of care, unless Care Contact	above in revoked	order to	provide lient.
Care Coordination Specific Information Status Report Information to Coor Initial Assessment Psychiatric Evaluat Psychological Evaluat Treatment Plan	to be disclosed: Recent Tr rdinate Care Discharge Medicatio ion Physical F	eatment/Progress Summary Information Health Information Secords/ IEP Sment	Notes [Other (specify)	3	
areas (i.e., domestic viole	thcare information/record contain include information about my ince) as it applies to my treatment and State laws and cannot	mental health, alcoh	iol and drug	depe	endence, STDs and H decstand that my reco	IIV / AIDS si	tatus and o	other specific
the disclosure of information of the control of the	ne federal privacy laws, the Hea on by and between healthcare and possible re-disclosure of p ws do apply and will continue to	providers, health inf ersonal health inforr	ormation cle	earin(dividi	ghouses and health pl	lans/health i	insurers 1	HIPAA does
writing, at any time. The r	se or disclose information expironditioned on signing this authoevocation will not have any effere of healthcare information. The	rization. This agree ect on actions taken	ement to rec before the r	quest revoc	t, release or share info cation is received by S	ormation ma	v he ravak	ed by me in
Client Signature: Date: / /								
If Appropriate- Parent/Guardian Signature: Date: / /					,			
Relationship to Client:		poointed \square C	uardiae Ua	alth -		Date:		/
Poforogenes DOM 70 00 . DO	Guardian-Other Specify:	ppointed U.G.	uaiuiaii-He	all(10	care Power of Attorne	ay .		